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ABSTRACT

Communities will need a significant infusion of resources in the future to care for persons with Acquired Immune Deficiency Syndrome (AIDS). The AIDS epidemic has served to confuse the differences between professional and volunteer roles of caregiving and has complicated the original intent of service by each of these groups. Recognition on the part of traditional agencies as well as new AIDS projects that volunteers have a vital function in service delivery is imperative. In fact, volunteers have often served to point the direction of future service roles for professionals. Clearly, the implications are that volunteers must be armed with knowledge and support to carry out their ever changing part in the delivery of care to the severely ill. It is necessary to encourage and support volunteer efforts, as well as to gear their expectations to reality. Internal social support should be offered to avoid volunteer attrition. Grass root organizations, as well as traditional social service agencies, should pay more attention to the social and educational needs of their staff. This attention to personnel will benefit the organization, the clients, and in the long run, the community. (ABL)

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PREVENTING VOLUNTEER BURN OUT THROUGH A STRUCTURED SUPPORT NETWORK

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

The projections by the Center for Disease Control suggest that communities will need a significant infusion of resources in the future to care for persons with AIDS. Serious illnesses often force people to rely on informal care systems to supplement the acute care hospitals provide. In the last twenty years there has been a rise in volunteers providing supplemental care to the seriously ill, a by-product of smaller families as well as governmental reductions in social service expenditures (Reisch and Wenocur, 1984). The AIDS epidemic has served to confuse the differences between professional and volunteer roles of care giving and has complicated the original intent of service by each of these groups. Given the irrational fears of contagion and the prejudices against homosexuals and the I.V. drug users which are rampant in the community, providing care to persons with AIDS outside a hospital has become especially problematic.

National responses to the AIDS crisis has served to increase the isolation of those trying to cope with the physical and emotional devastation of this disease. The media has reinforced blaming the victims for contracting the disease and the public, in general, has been in favor of identifying and isolating persons with AIDS (Singer and Rogers, 1986). While persons who are ill can benefit from receiving support, their ability to reciprocate can inhibit them from asking or cause them to set limits on the amount of help accepted (Shumaker and Brownell, 1984). These problems exist particularly in clients with

sexually transmitted diseases, who have feelings of self-hatred and the belief of deserved punishment brought on by "sinning" (Friedman, Levine and Siegel, 1987). Consumed by their predicaments, persons with AIDS can make it difficult for others to interact with them (Shinn, Lehmann and Wong, 1984). Volunteers who offer assistance can experience frustration when their attempts are not accepted or appreciated (Chesler and Barbarin, 1984).

It is important to recognize that while clients with AIDS can be a source of conflict for volunteers, so can community groups wishing to be educated. Developing and implementing preventative educational presentations for diverse populations are tasks for which local AIDS projects have also taken responsibility. These educational forays can receive hostile and confusing receptions (Chesler and Barbarin, 1984; Schumaker and Brownell, 1984), which result in volunteers becoming disappointed, bewildered and doubting their effectiveness.

Both clients and community groups wishing to be educated can strew obstacles in the volunteers path, and well-intentioned offers of help can backfire if they do not fit the occasion or the needs of the recipients. Cowen (1982:392) suggests that these problems may result from differences in the way help is offered, or depend on its origin. He concludes that volunteers' personal resources, i.e., finances, circle of friends, as well as personal ideologies and belief systems affect to whom they will

give help and, in turn, the kind of support given. The extra hardships of stigma surrounding AIDS as well as client differences in life style, personal philosophies, and the ability to cope with symptoms of the disease can turn the process of giving care into a stressful event for everyone involved.

In local AIDS projects, volunteers are expected to provide concrete services and emotional support to persons affected by the AIDS virus. Offering direct services to clients with AIDS, or HIV infection and their families takes enormous energies and places psychological strains on the care giver (Kayal, 1987). The workers exhausted and with a sense of isolation (Dunkel-Schetter, 1984; Newmark and Taylor, 1987), struggle with their clients' needs, demands and behaviors while trying to maintain some normalcy within their own lives. With an increase of social costs for the volunteer providers of care, it is useful to look at the transactional relationships that exist between persons requesting help or information around AIDS and those providing it.

The social support referred to in this paper is the ongoing interaction of both giving and receiving by the same individual whether client/patient/audience or volunteer. Relationships between people giving and people receiving support are seen as conditioned by a set of roles that are functionally linked (Pearlin, 1985). Discrete events such as personal ideologies, choice of friends or life style, are seen as influencing the type

and process of this ongoing support.

Gore (1981) and Thoits (1982) note the possiblity that certain life circumstances influence the availability as well as the kind of support offered. They suggest that stigmatizing illnesses such as psychiatric disorders and cancer can reduce the willingness of people to offer help. Depending on the difficulties encountered in interactions with others and the type of illness involved, a form of devaluation can occur, placing a stigma on persons with an illness and those involved in their care. The negotiating of realities between these people often involve strained encounters (Davis, 1961; Scott, 1969; Goffman, 1963). The stigma surrounding AIDS further narrows opportunities for social support. This disease associated with acts typically seen by society as deviant, has been used to express the public's social fears involving differences in class, race, ethnicity and sexuality (Brandt, 1987). Some of the potential sources of social support hesitate to be involved for fear AIDS will affect their own lives. Goffman (1963:30), explains, "In general, the tendency for a stigma to spread from the stigmatized individual to his close connections provides a reason why such relations tend either to be avoided or to be terminated where existing." This stigmatic spread has caused many volunteers and professionals to keep their AIDS activities hidden.

Training volunteers who freely give their time and services without remuneraton entail psycho-educational activities targeting

diverse groups about a range of issues. A broader interpretation of support from volunteers could also include providing attendant care, including physical care or nurturance, empathy, and encouragement, as well as material assistance, information and the sharing of experiences designed to enhance clients' well being. The organizational, social support, and social interaction literature strongly suggests that volunteer/client/audience adjustments will depend on what the costs and benefits are for each of these groups (Mechanic, 1978; Roth, 1972; Fiori, Becker and Copper, 1983).

AIDS, unlike other chronic illnesses, has periods of remission and reoccuring symptoms which take place over a short period of time. This appearance and disappearance of symptoms poses unique psychological strains for both the clients/patients and the care givers. Most human behavior is intentional, goal-oriented, and takes place with awareness of the consequences of acts (Quinney, 1979), people are redirecting and transforming their own actions in response to those of others (Blumer, 1969). New treatments, such as AZT, confuses care givers prepared for short term relationships. Extended time with clients increases the chance for emotional closeness and loss (Sosnowitz, 1985). Different situations, particularly involving critical emergencies, and frequent remissions for the person with AIDS, can require specific types and timing of help. In order to make a "goodness of fit," Shinn, Lehmann, and Wong (1984) suggest we

must consider several dimensions of support: the amount, the timing, and the source. They note that too much or too little help given at the wrong time by the wrong person may be problematic for the recipient. Pearlin (1985:50) on the other hand, urges us to consider the costs of providing support for the volunteers, both emotional and otherwise. He asks, "What happens to the relationship if the support is one-sided, lacking in the reciprocity and exchange...? And what happens when the best efforts to provide effective support fail? Do providers become burned out and withdraw from the relationship because it stands as a painful reminder of failure? When the same problem repeatedly surfaces, is caring replaced with anger; does the frustrated donor now both withhold help from and direct ire toward the recipient? Obviously, the giving and getting of supports can be an important and highly charged component of social interaction, one that can have a powerful impact on the relationship itself."

Careful planning is necessary to avoid excessive strains being placed on volunteers. We must consider the needs of volunteers who are increasingly expected to provide services to persons with AIDS. We recognize that they need preparation, encouragement, and emotional renumeration for their efforts. However, the difficulty in responding to the needs of volunteers is embedded in the organizational context in which they function. This paper will discuss how two AIDS projects provide a

structured support network as an insurance against future volunteer "burn out." By focusing on the volunteers, their adjustments and need for support to feel good about what they are doing, the clients ultimately benefit.

Organizations function in uncertain environments, especially in relation to resources. AIDS activities such as counseling and education, are less than standardized, due to the ever changing knowledge about the disease. This lack of standardization has put AIDS projects under pressure to increase their stability (Appleby, 1985). One option has been to formalize activities and centralize decisions to increase certainty. This same structure, while least supportive of volunteer's need for affirmation and socialization, is characteristic of professional agencies. Both Projects studied for this paper became increasingly more structured as they moved to conform to expectations of local human service and State funding requirements.

During this process of formalization, the volunteers providing direct service to AIDS clients pressed for greater role clarity with clients as well as within the organization. For instance, early in both Projects' history, before AZT, clients were dying in great numbers, often one or two within a period of a month. Field notes and minutes of meetings indicate that "buddies" providing care for these clients were feeling stress. They were requesting reference material on death and dying. They were also trying to define their actions and reactions in a

moving process while responding to the acts of other volunteers. The process of function and role clarification resulted in conflicts between the volunteers themselves, particularly around the differences in helping styles. This confusion contributed to a general feeling of unrest. Without an understanding of the dynamics of organizational growth and without a formal mechanism to resolve conflicts, with clients as well as with each other, the volunteers began to feel devalued and alienated from their "job" and their organization. The Projects were losing experienced "buddies," and at the same time having trouble recruiting new volunteers. Traditional social service agencies were studied to see how they handled recruitment and training of staff. It was learned that socially stigmatizing work can have appeal to volunteers. Particularly, if they can survive the type of scrutiny involved in an organized training program.

An in-service educational component was the first to develop. By taking account of what others were doing and saying, it was thought volunteers could become oriented in their course of action. Articles were circulated and discussed, experts were sought to speak on such issues as death and dying. The expectations of others served to define the concept of self as well as the role one was to occupy in a volunteer relationship. Potential "buddies" were asked to attend orientation seminars, be interviewed, and participate in meetings of experienced "buddies" hearing others discuss their client relationships. In this way,

symbolic cues, prior experience of other members, and the familiarity of the volunteers with each other served to organize a definition of stance common to the total organization. It also helped to formulate future responses to clients and the public.

Community education, client referral, and intake procedures developed simultaneously. It was thought that if a better match between clients and "buddies" occurred, disappointment, hurt feelings of rejection, and a more manageable situation for the "buddies" would result. Clients were evaluated by a team, both to cut down on volunteer stress and to bolster observations. Client and "buddy" matches were carefully thought out and whenever possible two "buddies," one experienced, were assigned to a client. The goal was to cut the strain of providing support by having it shared. Every interaction became a socializing experience for the volunteers (Stryker, 1980). Case presentations began to appear in "buddy" meetings (field notes 12/17/86). The benefits of talking about feelings and experiences of the "buddies" rather than those of the clients became obvious. There were some negative reactions, a few members voiced a feeling similar to being in group therapy and were opposed to revealing their emotions in public. Most found the sharing of feelings with their volunteer "community" a rich source of support and validation. As Lowy (1984:39) suggests, "Though psychic gratification cannot be imposed, it can be achieved if the agency creates a working environment that

promotes collegiality and collaboration." A strong group cohesiveness between the volunteers began to develop. They became clearer about their own needs of support from the larger group and the importance and responsiblity of other members to listen and respond. Experiences from the new and old "buddies" served to validate, invalidate or reshape the ongoing interactions between them. Volunteers, by taking the role of the other, began to anticipate the consequences of behaviors and actions with clients.

Providing support services for persons with AIDS has become increasingly more complex. The client profiles have changed. The majority of clients are no longer homosexual men but IV drug users, their sexual partners and their children. For organizations to respond to the changing needs of clients, the bureaucratic system of federal, state and city funding sources, as well as the ever changing information about the disease itself, they must be flexible and able to change components of their services rapidly. Clearly this involves a mechanism to change policies and train volunteers in a short period of time as well as retrain existing volunteers.

With AIDS becoming better publicized and the Projects more visable, requests to do volunteer "buddy" work have also increased. The amount of trained and eager "buddies" rose in these two Projects to the point where meeting places became over crowded and inadequate. The business part of meetings began to

take over the support part. New "buddies" became so plentiful that it was hard to KNOW them and make sound matches with new clients. The large pool of volunteers were broken down into more managable teams of eight in one Project, and graduate social work students were incorporated as case managers in the other to facilitate service flexibility.

However, as these procedures were put in to place, new problems arose. A lack of cohesiveness, a feeling of disconnectedness from the larger volunteer pool and the Project's board and staff has been one of the consequences of installing these new measures. It seems new management problems arise with each expansion of service and it has become necessary for both projects to hire staff who along with very active board members, coordinate and supervise volunteers.

While changes were occuring in the "buddy" support area, there were also simultaneous increases in the demands for prevention/educational presentations to diverse community groups. Some presentations were clearly not satisfactory. The volunteers took time off from work, took long hours to prepare, and carted video equipment, only to have five people show up, face a hostile audience or find these audiences diverted by other concerns. Further preparation was necessary for speaker-volunteers, as well as some opportunity to receive ongoing support. Volunteer speakers were encouraged to go in teams, one experienced, one in training. Required monthly meetings designed

to help in the preparation for specific audiences were required and particular audience needs were researched. Materials were reevaluated and matched to specific groups. Speaking engagements, as part of an in-service program, were instituted to provide needed practice for volunteers and feed back from their peers.

New formal orientations and in-service training for both Projects have been developed, occurring on a regular basis throughout the year. Each new volunteer is given core substantive AIDS knowledge and current issues are discussed in a series of required meetings. The history, philosophy, and structure of each project is presented. Orientation to different volunteer functions are presented before volunteers set out on a specific course of "buddy" work or speaking engagements.

The one area for these two AIDS projects that has not kept up with the changing clients profiles or the community expectations is the Hotline. The Hotline volunteers are few and new recruits hard to find. It appears that the Hotline has been unable to provide built in supports for its volunteers. Perhaps this has been partly due to both Projects having had the Hotline phones transferred from one individual home to another individual home for convenience and the pairing of experienced personnel with inexperienced volunteers has not worked as this involves much traveling. Both Projects are still grappling with this vital program component which fields both the clients and

community requests for service.

In conclusion, recognition on the part of traditional agencies as well as new AIDS projects that volunteers have a vital function in service delivery is imperative. In fact, volunteers often serve to point the direction of future service roles for professionals. Clearly, the implications are that volunteers must be armed with knowledge and support to carry out their ever changing part in the delivery of care to the severely ill. It is necessary to encourage and support volunteer efforts, as well as gear their expectations to reality. Internal social support should be offered to avoid volunteer attrition. The authors strongly suggest that grass root organizations, as well as traditional social service agencies, pay more attention to the needs, both social and educational, of their staff. This attention to personnel will benefit the organization, the clients and in the long run the community.

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